

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10035

CERTIFICATE OF DEATH

10029

1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Calvert

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN 1b

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Calvert County Hospital

3. NAME OF DECEASED
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

Booze

September 22

1961

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

Male

Negro

WIDOWED DIVORCED

8. DATE OF BIRTH

December 5, 1905

9. AGE (In years last birthday)

55

yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farmer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

13. FATHER'S NAME

Joseph T. Booze

14. MOTHER'S MAIDEN NAME

Cora Coates

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Otho Booze —brother

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

540.0

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

ACUTE MASSIVE HEMORRHAGE

gastric ulcer

INTERVAL BETWEEN
ONSET AND DEATH

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19
p. m.20d. INJURY OCCURRED
White Not white
at work at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from 9/20 1961 to 9/22 1961, that (I) (we) last saw the deceased alive on 9/2 1961, and that death occurred at 3:30 PM, from the causes and on the date stated above.

22a. SIGNATURE

John W. Bell

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS.22b. DATE
SIGNED22c. PHYSICIAN'S
NAME (Type)

R. DeVillarreal M.D.

22d. ADDRESS

St. Leonards, Maryland

9/23/61

(State)

Md

23a. BURIAL, CREMATION,
REMOVAL (Specify)23b. DATE THEREOF
9-25-61

23c. NAME OF CEMETERY OR CREMATORI

Moses

23d. LOCATION (City, town, or county)

AA

(State)

Md

24. FUNERAL DIRECTOR'S SIGNATURE

R. J. Bell

ADDRESS

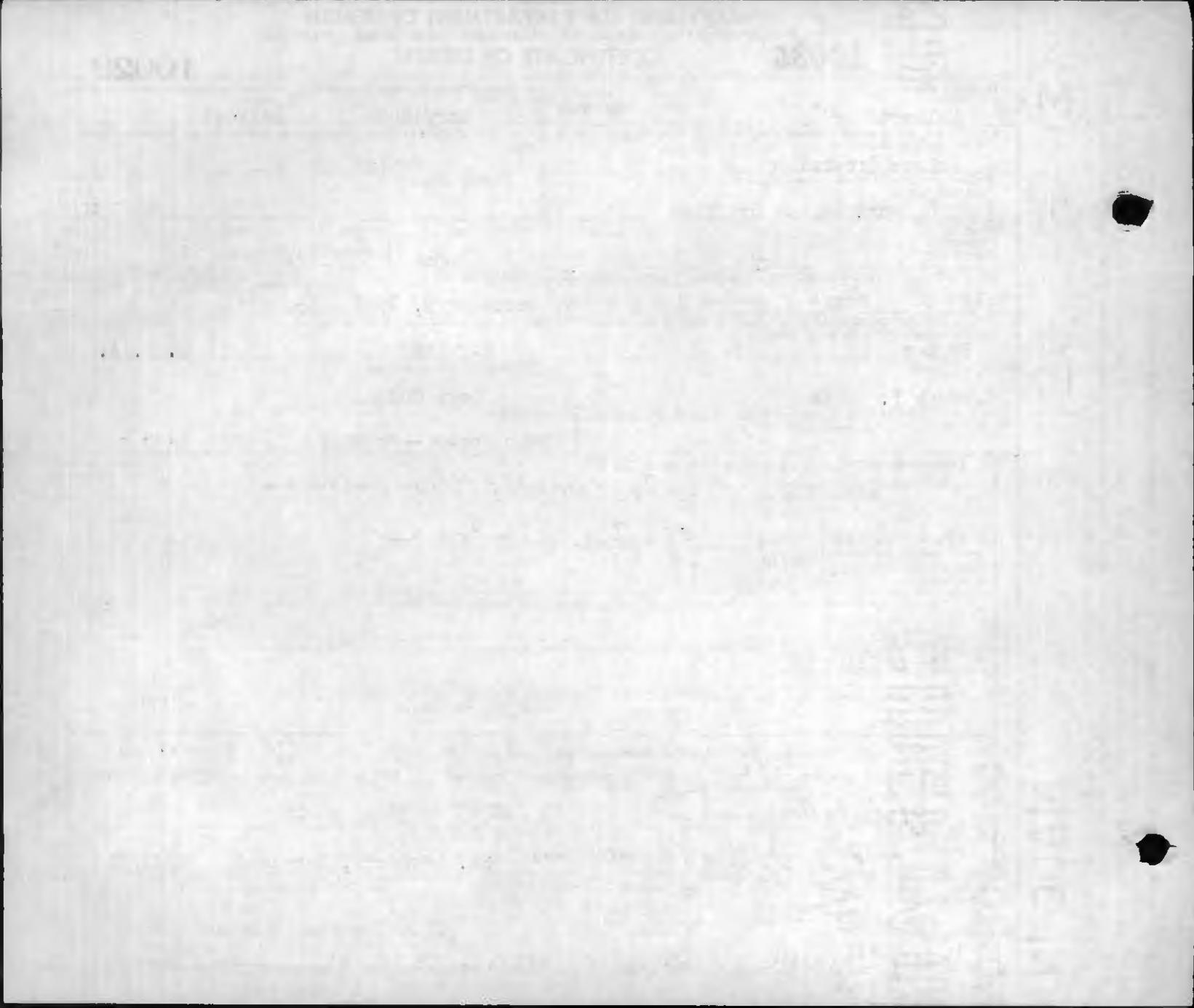
Prince Frederick, Md

25a. REC'D BY REGISTRAR

DATE SEP 28 '61

25b. REGISTRAR'S SIGNATURE

Arthur S. Tamm



INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed in 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the register within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the signed copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10037

CERTIFICATE OF DEATH

10030

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <i>Calvert</i> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Ch. Beach</i>			2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Calvert CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Chesapeake Beach</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Residence P. O. Box #96			STREET ADDRESS P. O. Box 96 (If rural give location)		
3. NAME OF DECEASED (Type or Print) <i>FLORENCE ESTELLE</i>			4. DATE (Month) (Day) (Year) OF DEATH <i>Sept 14 1961</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <i>August 11, 1894</i>	9. AGE last birthday 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>	11. BIRTHPLACE (State or foreign country) <i>Forestville, Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Christopher Hayes</i>			14. MOTHER'S MAIDEN NAME <i>Lucinda Beatley</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <i>579-88-1877</i>	17. INFORMANT & ADDRESS Adams E. Dyer, PO Box 96, Maryland	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH IMMEDIATE CAUSE <i>420.1 Coronary occlusion</i> (A) ANTECEDENT CAUSE(S) DUE TO <i>Coronary Heart disease</i> (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) <i>Forestville</i> (State) <i>Md</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>13 Sept 61</i> to <i>14 Sept 61</i> , that I last saw the deceased alive on <i>14 Sept 61</i> , and that death occurred at <i>8:30 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>G.W. Levens</i> ADDRESS <i>Huntingtown Md</i> DATE SIGNED <i>9/14/61</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9/18/61</i>		NAME OF CEMETERY OR CREMATORIAL <i>Epiphany Cemetery</i>	
24. REC'D BY REGISTRAR DATE <i>SEP 19 61</i>		REGISTRAR'S SIGNATURE <i>Arthur S. French</i>		LOCATION (City, town, or county) <i>Forestville</i> (State) <i>Maryland</i>	
25. FUNERAL DIRECTOR'S SIGNATURE <i>W.W. Chambers</i> ADDRESS <i>517 11 St., Wash. 3, D. C.</i>					

ST. DOMINICUS - STATION TO THE TEASING STATE CHURCH

REGULAR STATION TO STATION

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FOR STATE
HEALTH DEPT.
M
11-20-61 a.m.s

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10038 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 10031

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any detail is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Calvert	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach	b. COUNTY Calvert						
c. LENGTH OF STAY IN 18	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North Beach						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS None						
3. NAME OF DECEASED (Type or print)	First Birket	Middle Lee	Last FRAZIER	4. DATE OF DEATH Sept 30 1961	Month Day Year		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 30, 1905	9. AGE (In years last birthday) 56 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME M. R. Frazier		14. MOTHER'S MAIDEN NAME Nancy Owen		Address			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service)		16. SOCIAL SECURITY NO. 579-42-7697		17. INFORMANT Mrs. B.Z. Frazier			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 500X DUE TO Asphyxia Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. (b) Edema and hemorrhages in lungs XORIGIN (c) Tracheo-bronchitis, acute, with mucous plugs							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Howard Shaub, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Oct 1, 1961					DATE SIGNED
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 3/61		22c. NAME OF CEMETERY OR CREMATORIAL Family		22d. LOCATION (City, town, or country) Culpeper Va (State)	
23. FUNERAL DIRECTOR First Funeral Peppers, by Helmut		ADDRESS Culpeper, Virginia		24e. REC'D BY REGISTRAR DATE OCT 2 '61		24f. REGISTRAR'S SIGNATURE Cynthia L. Thomas	

1800

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, give RURAL and give nearest town) <i>Briontjor</i>		c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Briontjor</i>	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George</i>		First <i>George</i>	Middle <i>Freeland</i>
4. DATE OF DEATH Month <i>9</i>		Month <i>12</i>	Year <i>1961</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>EC</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <i>March 15 1881</i>	9. AGE (In years last birthday) <i>80</i> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>53-302-460</i>	
13. FATHER'S NAME <i>John Freeland</i>		14. MOTHER'S MAIDEN NAME <i>Jean Russell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-38-8667</i>	
17. INFORMANT <i>Maggie Washington, 1812</i>		Address <i>33-302-460</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Age</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE/CONDITION GIVEN IN PART I(a) <i>Had been sick now weeks</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. EXTERNAL CAUSE (Was PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.)	
20c. TIME OF INJURY <i>5:30 p.m.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>9/12 1961</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>	
20f. (City or town) <i>Briontjor Calvert Md</i>		(County) <i>(State)</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>9-16-61</i>		22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Plum Point</i>	
22d. LOCATION (City, town, or county) <i>Plum Point, Calvert, Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Finney E. Sewell, Pr. Frederick, Md</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 19 '61</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10040

10033

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 064		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick, Md.		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Clarence M. Gott	Middle	Last	4. DATE OF DEATH	Month September 13, 1961	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 8, 1875	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Tenniel D. Gott		14. MOTHER'S MAIDEN NAME Courtney Oigoo		Address Mrs. Lee Bowen, Bartow, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 312-38-3151		17. INFORMANT Mr. Lee Bowen, Bartow, Md.		INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Cerebral accident			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above.							
22a. SIGNATURE G. J. Weems		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/14/61			
22c. PHYSICIAN'S NAME (Type) G. J. Weems		22d. ADDRESS Huntingtown					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept 16, 1961		23c. NAME OF CEMETERY OR CREMATORIUM Wesley Cemetery		23d. LOCATION (City, town, or county) (State) Prince Frederick, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE G. J. Harkness Son Mutual Ad.		ADDRESS		25a. REC'D BY REGISTRAR SEP 18 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hayes	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be reh. by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

VR A15 (4)
 1SM 9/59

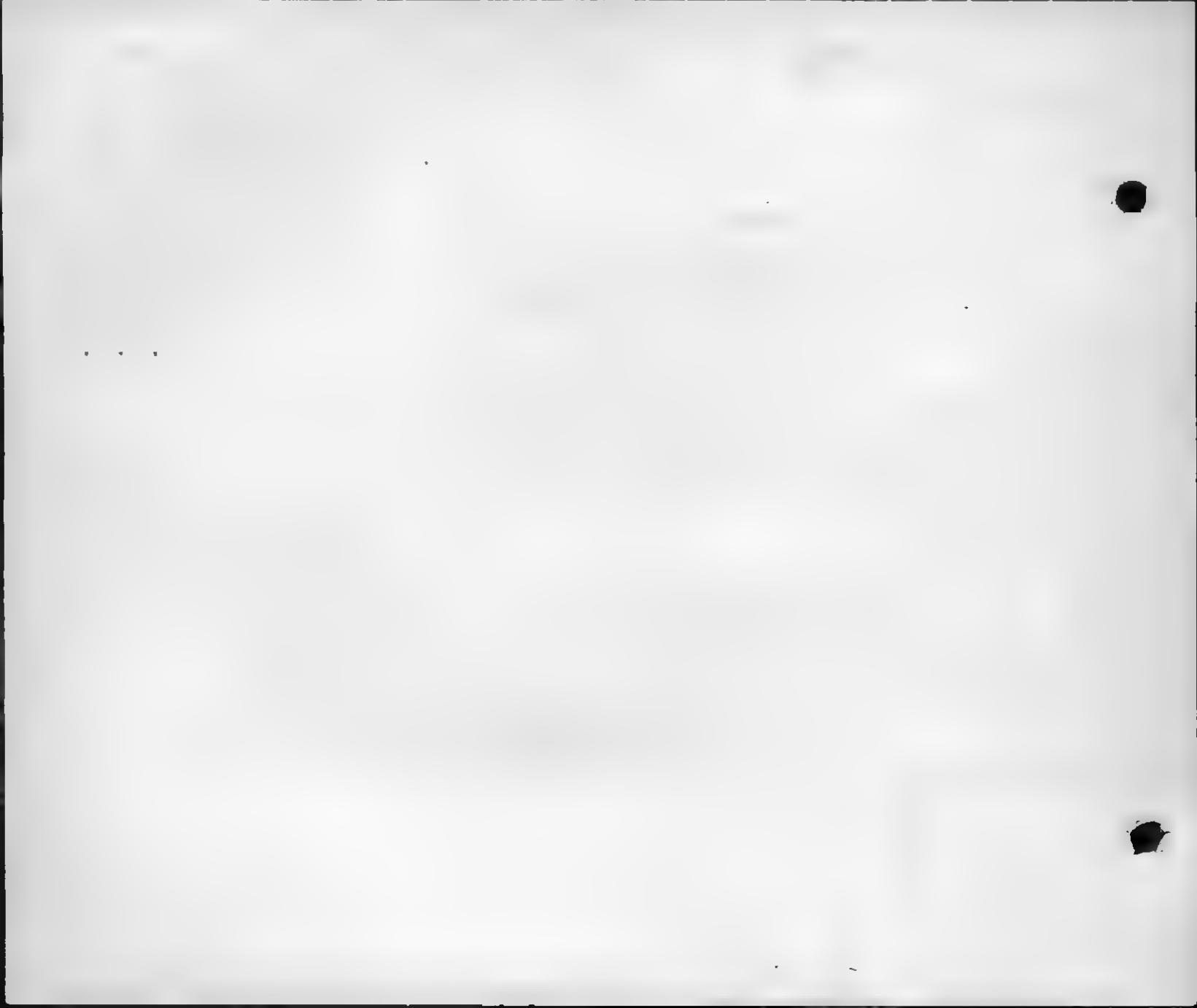
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10041

10034

1. PLACE OF DEATH o COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland		b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b Calvert County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Leonards		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Harry		First	Middle	Last	4. DATE OF DEATH September 22 1961	Month	Day	Year	
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 12, 1880	9. AGE (In years last birthday) 80 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Joseph Gray		14. MOTHER'S MAIDEN NAME Sarah Gray							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT 147-01-9640 Mary Gray wife		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 610X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>9/20</u> 19 <u>61</u> to <u>9/22</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>9/20</u> 19 <u>61</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.		22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) <u>R. DE VILLE CARRERA MD</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22d. ADDRESS <u>St. Leonard</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) 9-26, 61		23c. NAME OF CEMETERY OR CREMATORIAL Brooks		23d. LOCATION (City, town, or county) Island Creek		(State) Md			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hinkley Sewell</u>		ADDRESS Prince Frederick, Md		25a. REC'D BY REGISTRAR DATE SEP 28 '61		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>			



ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL
TO FUNERAL DIRECTOR

may be removed by the hospital or attending physician.

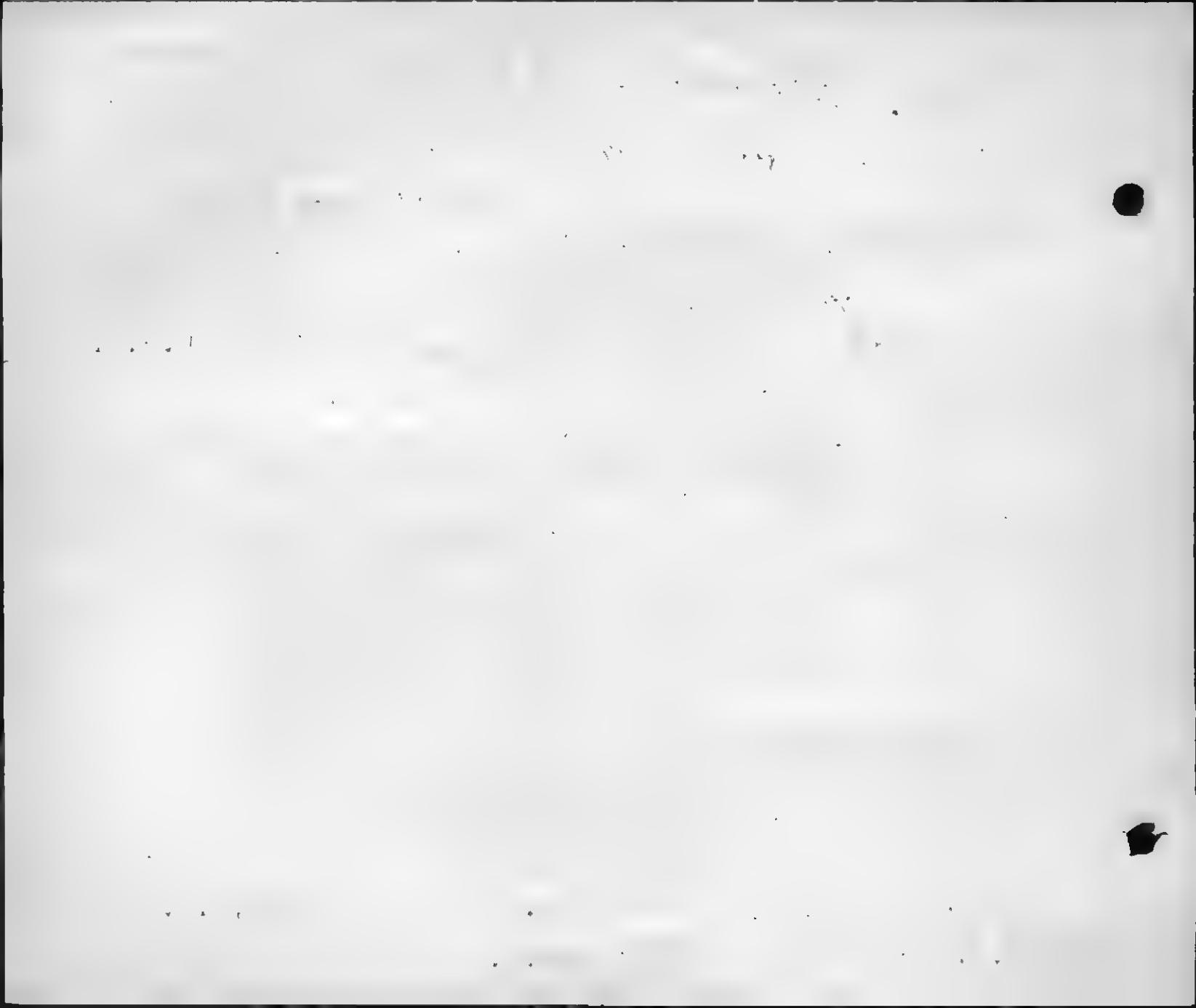
15M 15S

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10042 Items 13 & 14 Film 0297 10/3/61 Mh
10035

1. PLACE OF DEATH Breezepoint Beach Maryland		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
D. COUNTY CALVERT		D. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HONTING TOWN		c. LENGTH OF STAY IN 1b 11 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL	
3. NAME OF DECEASED (Type or print) Carl Ashton M. TIN HARTMAN		d. STREET ADDRESS Breeze Point Beach Maryland	
S. SEX M		4. DATE OF DEATH SEPT 23 1961	
6. COLOR OR RACE W		5. DATE OF BIRTH JAN 13 1892	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY BRICKLAYER	
11. BIRTHPLACE (State or foreign country) Baltimore Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel V. HARTMAN		14. MOTHER'S MAIDEN NAME MINNIE E. FISHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. MRS Eva DUVALL	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 5 MIN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease		18 MONTHS	
DUE TO (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) No	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 20 to Sept 23, 1961 , that (I) (we) last saw the deceased alive on July 29, 61 , and that death occurred at 74 M , from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE Page Jett		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) PAGE C JETT		22d. ADDRESS PRINCE FREDERICK Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9-26-61	
23c. NAME OF CEMETERY OR CREMATORIAL Glenwood Cemetery		23d. LOCATION (City, town, or county) (State) Washington, D. C.	
24a. FUNERAL DIRECTOR'S SIGNATURE W. H. Funtemann & Son		24b. ADDRESS 5732 Georgia Ave N. W.	
25a. REC'D BY REGISTRAR Arthur L. Thomas		25b. REGISTRAR'S SIGNATURE	
DATE SEP 27 '61			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

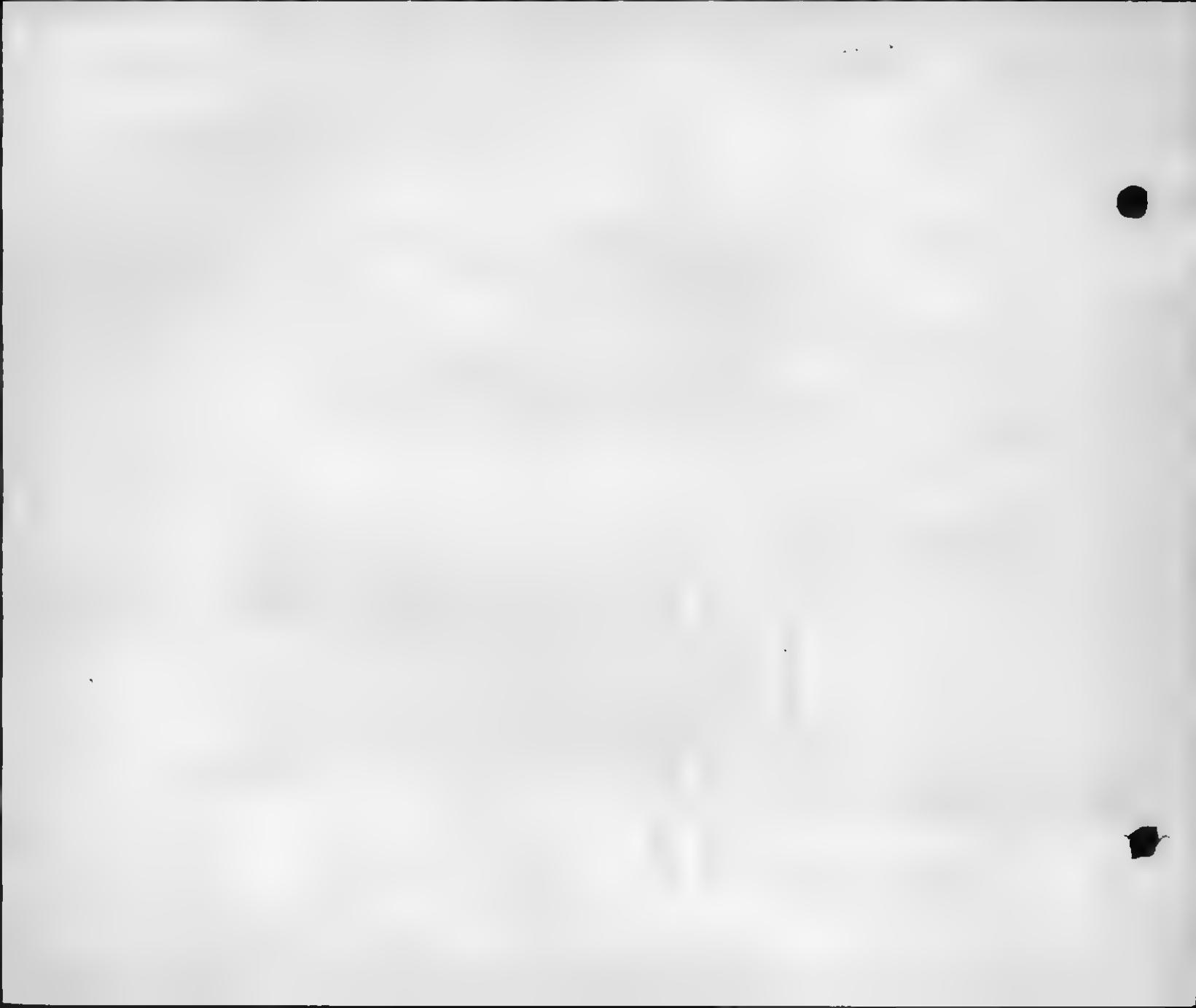
10043

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG'D NO. 10043

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. If a burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Calvert		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Huntingtown		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First Emma	Middle C	Last Harvey	4. DATE OF DEATH Sept. 14, 1961	Month Sept.	Day 14	Year 1961
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March, 3, 1880	9. AGE (In years last birthday) 81 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Louis Hoye		14. MOTHER'S MAIDEN NAME Alice Giles						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes, no, or unknown] [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Josephine Ray, Huntingtown, Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Coronary occlusion				INTERVAL BETWEEN ONSET AND DEATH		
		arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none						
20c. TIME OF INJURY Hour o. m. p. m. 14 Sept 61		Month, Day, Year 14 Sept 61	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE G. J. Weems		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 14 Sept 61		
EXAMINER'S NAME (Type) G. J. Weems		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) 9-16-61		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Hope		22d. LOCATION (City, town, or county) Sunderland		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Pinkney E. Servell, Pr. Frederick, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 19 '61		24b. REGISTRAR'S SIGNATURE Charles S. Krause		



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10044 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 1 (Fill in) Gcy 10/11/61 1wk

Reg. Dist. No. 10037

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institutions, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 month</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co H</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>George F. H. ITGEN</i>		First <i>George</i>	Middle <i>F.</i>
4. DATE OF DEATH <i>Sept. 26, 1961</i>		Month <i>Sept.</i>	Day <i>26</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Feb. 21, 1885</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Unknown</i>	
11. BIRTHPLACE (State or foreign country) <i>Unknown</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Keamer</i>		14. MOTHER'S MAIDEN NAME <i>Emma Frick</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Unknown</i>		Address <i>Unknown</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>78</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. DUE TO <i>Eye</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Unknown</i>	
DUE TO <i>Eye</i>			
DUE TO <i>Unknown</i>			
DUE TO <i>Unknown</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <i>Die suddenly at home</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>10 p.m. 9/26/61</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>None</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bridge, etc.) <i>None</i>		20f. (City or town) <i>None</i>	
(County) <i>None</i>		(State) <i>None</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>None</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>H. W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept. 30, 1961</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Dry Hill Cemetery</i>		22d. LOCATION (City, town, or county) <i>Philadelphia, Pa</i>	
(State) <i>None</i>		(State) <i>None</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness & Son - Mutual, Inc.</i>		ADDRESS <i>None</i>	
24. REC'D BY REGISTRAR <i>9/29/61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	
DATE <i>None</i>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

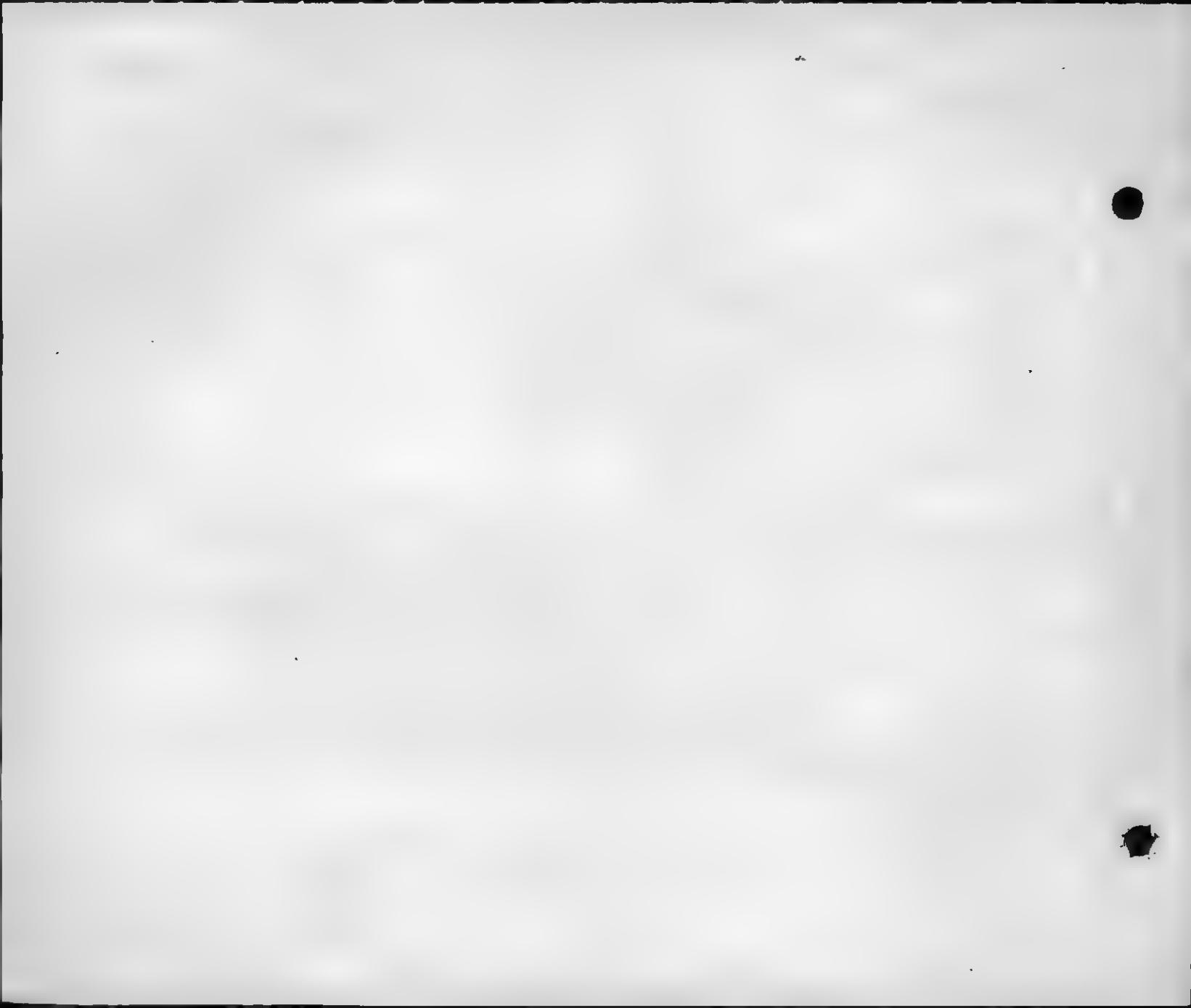
10045

10038

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) b. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Some Frederick</i>		c. LENGTH OF STAY IN 1b <i>Calvert Co Md</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Calvert Co H</i>		d. STREET ADDRESS <i>Some Frederick</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Bessie</i>	First <i>H.</i>	Middle <i>Em</i>	Last <i>9</i>			
4. DATE OF DEATH <i>Aug 4, 1874</i>	Month <i>8</i>	Day <i>22</i>	Year <i>1961</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1874-8-9</i>			
9. AGE (In years last birthday) <i>87 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	11. BIRTHPLACE (State or foreign country) <i>Md</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Thomas L. Harkness</i>	14. MOTHER'S MAIDEN NAME <i>Elaine Bower</i>	Address <i>Poland Spring Company Rd</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Type, no. or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT <i>None</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio vascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Associated with a fracture</i> DUE TO (b) <i>Age of 3 yrs old</i> (c) <i>No details</i>	INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs</i>		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>None</i>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>None</i>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1b or Part 1f if applicable) <i>None</i>	20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>9 127 61</i>				
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>None</i>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>	20f. (City or town) <i>None</i>	(County) <i>None</i>			
20g. (State) <i>None</i>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> <i>H. W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <i>9/22/61</i>			
ACTUAL SIGNATURE <i>H. W. WARD</i>	EXAMINER'S NAME (Type) <i>H. W. WARD</i>	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Sept. 27, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>	22d. LOCATION (City, town, or county) <i>Barstow - Calvert - Md</i>	(State) <i>None</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. G. Harkness & Son - Mutual, Inc.</i>	ADDRESS <i>None</i>	24a. REC'D BY REGISTRAR <i>SEP 26 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Carling S. Knott</i>			



TO HOSPITAL/ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10046

CERTIFICATE OF DEATH

10039

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Calvert			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PE. Frederick		c. LENGTH OF STAY IN 1b 7 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Beach		d. STREET ADDRESS 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First John	Middle J	Last madigan	4. DATE OF DEATH Month 9	Month 7	Day 1961	Year		
S. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 9 1893	9. AGE (in years (1st birthday) yrs. 68	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newspaper (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Washington, DC		12. CITIZEN OF WHAT COUNTRY? US			
13. FATHER'S NAME William F. Madigan		14. MOTHER'S MAIDEN NAME MARY A. Hill							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-10-2101		17. INFORMANT William F. Madigan		Address 47 Gleasen St NE Washington, DC.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinoma of Stomach		INTERVAL BETWEEN ONSET AND DEATH					
151X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO									
DUE TO (c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Mastectomy to liver & lungs							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) Bladensburg		(State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 8/31/61 to 9/7/61 , that (I) (we) last saw the deceased alive on 7/7/61 , and that death occurred on 9/5/61 M, from the causes and on the date stated above.									
22a. SIGNATURE H. Whland		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED Aug 28 1961	
22c. PHYSICIAN'S NAME (Type) Dr. J. J. Whland		22d. ADDRESS 1310 1/2 E. 20th St.							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9-11-61		23c. NAME OF CEMETERY OR CREMATORIUM FT. LINCOLN		23d. LOCATION (City, town, or county) Bladensburg			(State) MD.
24. FUNERAL DIRECTOR'S SIGNATURE Timothy Hanlon - 3831 - G.A. AVE. N.W.		ADDRESS 1310 1/2 E. 20th St.		25a. REC'D BY REGISTRAR DATE SEP 14 '61		25b. REGISTRAR'S SIGNATURE Charles S. Evans			

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

10047

CERTIFICATE OF DEATH

10040

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>		c. LENGTH OF STAY IN 1b <i>35 yrs.</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Solomons</i>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS —						
3. NAME OF DECEASED (Type or print) <i>Christian C. S. Pedersen</i>		First <i>C.</i>	Middle <i>S.</i>					
4. DATE OF DEATH <i>Sept. 25</i>	Month <i>Sept.</i>	Day <i>25</i>	Year <i>1961</i>					
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb. 3 1893</i>					
9. AGE (In years last birthday) <i>68 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Boat Rigger</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Boat Rigger</i>	11. BIRTHPLACE (State or foreign country) <i>Aarhus Denmark</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>					
13. FATHER'S NAME <i>Peter Pedersen</i>	14. MOTHER'S MAIDEN NAME <i>Caroline Rasmussen</i>	Address <i>220-16790a Gladys E. Pedersen, Solomons, Md.</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>220-16790-00</i>	17. INFORMANT <i>Gladys E. Pedersen, Solomons, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Coronary Occlusion</i> <i>Generalized arteriosclerosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) —	20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —	20f. (City or town) —	(County) —	(State) —	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above.								
22a. SIGNATURE <i>R. E. Glanzer</i>	M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>9/26/61</i>			
22c. PHYSICIAN'S NAME (Type) <i>R. E. Glanzer</i>	22d. ADDRESS <i>St. Leonard</i>							
23a. BURIAL, CREMATION, REMOVAL* (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Sept. 27, 1961</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Solomons Methodist Cemetery</i>	23d. LOCATION (City, town, or county) <i>Solomons</i>	(State) <i>Md.</i>				
24. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harbance & Son, Mutual, Md.</i>	ADDRESS <i>A. A. Harbance & Son, Mutual, Md.</i>	25a. REC'D BY REGISTRAR DATE <i>SEP 29 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harbance</i>					

